AIDS DRUG ASSISTANCE PROGRAM

2025-26

November Estimate

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Table of Contents

I. Program Overview

The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA), Acquired Immunodeficiency Syndrome (AIDS) Drug Assistance Program (ADAP) Branch administers ADAP and the Pre-Exposure Prophylaxis Assistance Program (PrEP-AP). ADAP provides access to life-saving medications, health insurance premium payment assistance, and assistance with medical out-of-pocket costs for eligible California residents living with Human Immunodeficiency Virus (HIV). PrEP-AP provides assistance with medication and medical out-of-pocket costs related to HIV pre-exposure prophylaxis (PrEP) for clients at risk for acquiring HIV and post-exposure prophylaxis (PEP) for clients who may have been exposed to HIV. Services are provided to five groups of clients:

1. **Medication-only clients** are people with HIV (PWH) who do not have private insurance and are not enrolled in Medi-Cal or Medicare. ADAP covers the full cost of prescription medications on the ADAP formulary for these individuals. This group only receives services associated with medication costs.

2. **Medi-Cal Share of Cost (SOC) clients** are PWH enrolled in Medi-Cal who have a SOC for Medi-Cal services. ADAP covers the SOC for medications for these clients. This group only receives services associated with medication costs.

3. **Private insurance clients** are PWH who have some form of health insurance, including insurance purchased through Covered California, privately-purchased health insurance, or employer-based health insurance. This group is divided into three client sub-groups: Covered California clients, non-Covered California clients, and employer-based insurance clients. These groups receive medication benefits and may also receive assistance with health insurance premiums and medical out-of-pocket costs.

4. **Medicare clients** are PWH who are enrolled in a Medicare plan. This group is divided into three client sub-groups: Part B, Part C, and Part D. These groups receive medication benefits and may also receive assistance with health insurance premiums and medical out-of-pocket costs.

5. **PrEP-AP clients** are HIV-negative individuals who are at risk of HIV infection and who have chosen to take PrEP as a way to prevent infection. For insured clients, PrEP-AP pays for PrEP and PEP related medical out-of-pocket costs and covers the gap between what the client's insurance plan and the manufacturer's copayment assistance program pays towards medication costs. For uninsured clients, PrEP-AP only provides assistance with PrEP and PEP-related medical costs and medication costs for clients who are ineligible for a medication assistance program through a drug manufacture or other assistance programs.

As a covered entity in the Health Resources & Services Administration (HRSA) 340B Drug Pricing Program, ADAP collects rebates for most prescriptions purchased for ADAP clients. ADAP does not collect rebates for prescriptions purchased for Medi-Cal SOC or PrEP-AP clients. To prevent duplicate rebate discounts on the same claim, which is prohibited, ADAP does not invoice manufacturers for rebates on Medi-Cal SOC claims. As the primary payer, Medi-Cal has the right to claim mandatory rebate on prescriptions for Medi-Cal SOC clients. ADAP also does not collect rebate on medication purchases for PrEP-AP clients because PrEP-AP is separate and distinct from ADAP and is not a 340B covered entity.

Historically, most ADAP clients were medication-only clients without health insurance because PWH were unable to purchase affordable health insurance in the private marketplace. With the implementation of the Affordable Care Act, more ADAP clients have been able to access public and private health insurance coverage. ADAP clients are screened for Medi-Cal eligibility and potentially eligible clients must apply to safeguard ADAP as the payer of last resort. Clients who enroll in full-scope Medi-Cal are disenrolled from ADAP because these clients have no SOC, no drug copays or deductibles, and no premiums. All clients who obtain health coverage through Covered California or other health plans can remain in ADAP's medication program to receive assistance with their drug deductibles and copays for medications on the ADAP formulary.

Eligible clients with health insurance can also coenroll in ADAP's health insurance assistance programs for assistance with their insurance premiums and medical out-of-pocket costs, which can only be paid if ADAP pays the client's premium. Helping ADAP clients purchase and maintain comprehensive health insurance is more cost effective than paying the full cost of medications and improves health outcomes by providing access to the full spectrum of medical care beyond the HIV outpatient care and medications available through the HRSA Ryan White HIV/AIDS Program (RWHAP).

II. Estimate Methodology

The ADAP Estimate uses a Cost Per Client methodology to estimate expenditure and revenue associated with medication and insurance assistance services as they relate to changes in the volume of activity. This methodology looks at two input variables, the number of clients served and cost per service/expenditures per client, to calculate the estimated number of expenditures for service provided. Forecasts are modeled conservatively, with the objective of reducing the risk of underestimating budget needs.

A. Expenditure Forecasts

Program data describing client counts and costs per client are summarized by month and insurance coverage group and combined with external cost drivers which account for trends in current and historical program growth, changes in pharmacy utilization, administrative policies, and seasonal effects.

Separate estimates are created for each insurance coverage group and total projected costs are based on the following drivers:

- Expected number of clients served per month
- Expected cost per client per month

Total costs are estimated by multiplying the expected cost per client by the expected number of clients per month.

B. Revenue Forecasts

Revenue is estimated based on the results of the expenditure forecasts, historical rebate payment amounts, average time between medication dispense, and receipt of rebate payments.

Revenue is estimated by quarter to reflect manufacturer agreements and may be adjusted to reflect expected implementation of any newly negotiated voluntary rebate terms.

III. Estimate Overview

The 2025-26 ADAP November Estimate provides revised projections of 2024-25 and 2025-26 Local Assistance costs for medication, health insurance premiums, medical out-of-pocket costs, administrative costs associated with pharmacy, insurance and medical benefits management services, and ADAP enrollment site payments. Total estimated budget authority needs for 2024-25 and 2025-26, below, include all assumptions.

Table 1 displays the estimated ADAP Local Assistance budget authority need for 2024-25 (column C) and 2025-26 (column G) and compares that need to the amount reflected in the 2024-25 Budget Act (column B for 2024-25, and column F for 2025-26)[1]. The Budget Act of 2018 authorized an ongoing $2 million in budget authority to modify and expand PrEP-AP which is included with the ADAP Rebate Fund (Fund 3080) budget authority need detailed below.

- 2024-25: OA estimates the ADAP budget authority need will be $392.5 million ($277.3 million ADAP Rebate Fund (Fund 3080) and $115.2 million Federal Trust Fund (Fund 0890)), which is $1.8 million lower than reported in the 2024-25 Budget Act (Table 1). The 0.4 percent decrease is driven primarily by staggered implementation of stakeholder proposals/legislative requirements outlined in Senate Bill (SB) 159 (Chapter 40, Statutes of 2024, Section 83(a)), generating higher medication and insurance premium expenditures than previously estimated (Table 7)[2], offset by the September 25, 2024, veto of SB-954. A one-time Early Action Package allocation available in Fiscal Year (FY) 2024-25 until June 30, 2027, was contingent on the passage of SB-954.
- 2025-26: OA estimates the ADAP budget authority need will be $462.3 million ($352.0 million ADAP Rebate Fund (Fund 3080) and $110.3 million Federal Trust Fund (Fund 0890)), which is $51.8 million higher than reported in the 2024-25 Budget Act (Table 1). The 12.6 percent increase is driven primarily by the same factors above and higher PrEP-AP medication expenditures than previously estimated (Table 10)[3].

[1] Table 1 includes increases to the ADAP Rebate Fund expenditure authority, associated with the Early Action Package, that were not included in the 2024-25 ADAP May Revision Estimate; $17.6 million in FY 2024-25 and $33.8 million in FY 2025-26.
[2] Table 7 includes a $17.6 million increase to the ADAP Rebate Fund expenditure authority, associated with the Early Action Package, that was not included in the 2024-25 ADAP May Revision Estimate.
[3] Table 10 includes a $33.8 million increase to the ADAP Rebate Fund expenditure authority, associated with the Early Action Package, that was not included in the 2024-25 ADAP May Revision Estimate.

Table 2 displays the estimated ADAP revenue for 2024-25 (column C) and 2025-26 (column G) and compares them to the amount reflected in the 2024-25 Budget Act (columns B for 2024-25 and column F for 2025-26).

- 2024-25: OA estimates ADAP revenue will be $329.6 million (Table 2), $19.6 million higher than reported in the 2024-25 Budget Act. The 6.3 percent increase is driven primarily by receipt of updated interest income data.
- 2025-26: OA estimates ADAP revenue will be $319.7 million (Table 2), $9.7 million higher than reported in the 2024-25 Budget Act. The 3.1 percent increase is driven primarily by the same factor above.

California Department of Public Health
AIDS Drug Assistance Program and PrEP Assistance Program
2025-26 November Estimate
Table 1: Local Assistance Budget Authority
(In Thousands)

Local Assistance	2024-25 Budget Act	Current Year 2024-25			2024-25 Budget Act	Budget Year 2025-26		
		November Estimate	$ Change from Budget Act	% Change from Budget Act		November Estimate	$ Change from Budget Act	% Change from Budget Act
(A)	(B)	(C)	(D) =(C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Funds Requested	**$394,270**	**$392,507**	**-$1,762**	**-0.4%**	**$410,470**	**$462,276**	**$51,806**	**12.6%**
Federal Trust Fund - Fund 0890	$100,774	$115,230	$14,457	14.3%	$100,774	$110,263	$9,489	9.4%
ADAP Rebate Fund - Fund 3080	$293,496	$277,277	-$16,219	-5.5%	$309,696	$352,013	$42,317	13.7%
Caseload	31,548	34,243	2,695	8.5%	31,548	37,488	5,940	18.8%

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
ADAP Rebate Fund - Fund 3080 authority includes an ongoing $2 million from the 2018 Budget Act.

2025-26 November Estimate
Table 2: ADAP Rebate Fund (Fund 3080) Revenues
(In Thousands)

Revenue	2024-25 Budget Act	Current Year 2024-25			2024-25 Budget Act	Budget Year 2025-26		
		November Estimate	$ Change from Budget Act	% Change from Budget Act		November Estimate	$ Change from Budget Act	% Change from Budget Act
(A)	(B)	(C)	(D) =(C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Revenue Requested	**$309,995**	**$329,581**	**$19,586**	**6.3%**	**$309,995**	**$319,674**	**$9,679**	**3.1%**
ADAP Rebate Fund - Fund 3080	$307,753	$311,493	$3,740	1.2%	$307,753	$301,586	-$6,167	-2.0%
Interest Income	$2,242	$18,088	$15,846	706.8%	$2,242	$18,088	$15,846	706.8%

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

IV. Summary of Expenditures and Revenue

A. Expenditure Types

ADAP variable expenditures are broken out into two types: health care expenditures and administrative expenditures.

a) Health care expenditures include prescription medication costs for drugs on the ADAP formulary (including deductibles, copays, and co-insurance), health insurance premiums, and medical out-of-pocket

costs (e.g., deductibles and copays for physician visits, laboratory tests, etc.). Estimated expenditures by client group are shown in Table 3. A detailed display of caseload and expenditures by client group and service type is in Section VI, Tables 6 – 11.

b) Administrative expenditures include costs associated with pharmacy, insurance and medical benefits management services; and payments to local ADAP and PrEP-AP enrollment sites for services needed to enroll and maintain clients in ADAP and PrEP-AP. Administrative expenditure estimates are adjusted annually through the ADAP Estimate, based on caseload and service projections. Estimated expenditures for administrative services are also shown in Table 3.

TABLE 3: ESTIMATED VARIABLE EXPENDITURES BY CLIENT GROUP

CLIENT GROUP	EXPENDITURES	
	FY 2024-25	FY 2025-26
Medication-Only	$228,013,305	$249,523,961
Medi-Cal SOC	$799,595	$908,835
Private Insurance	$107,924,777	$131,092,117
Medicare	$20,882,170	$26,510,933
PrEP-AP	$20,528,177	$37,155,125
SUBTOTAL	**$378,148,023**	**$445,190,972**
Admin: ADAP	$5,546,912	$6,101,603
Admin: PrEP-AP	$5,361,163	$5,384,963
Admin: Enrollment	$7,825,500	$8,335,500
Health Management Systems (HMS)	-$16,373,540	-$14,736,186
Early Action Package	$10,000,000	$10,000,000
TOTAL	**$390,508,058**	**$460,276,852**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

B. Revenue and Federal Grants

a) ADAP Special Funds – ADAP receives both mandatory and voluntary supplemental rebates from drug manufacturers for ADAP medication expenditures. An approximate six-month delay in receipt of rebate revenue, from the time the medication expenditure occurs, exists because of the time required for billing the drug manufacturers. 2024-25 revenue projections are based on actual and estimated rebates from actual and estimated medication expenditures from January through December 2024. 2025-26 revenue projections are based on estimated rebates from estimated medication expenditures from January through December 2025.

b) Federal Funds – ADAP receives federal funds from HRSA through the Ryan White Part B Program.

- 2024-25: Total federal fund budget authority is projected to be $115.2 million (Table 1), $14.5 million (14.3 percent) higher than reported in the 2024-25 Budget Act. Federal fund budget authority includes the following federal grant assumptions:
  - 2024 Ryan White Part B: $94.7 million
  - 2024 Ryan White Part B Supplemental: $9 million
  - 2024 ADAP Emergency Relief Funds (ADAP Shortfall Relief): $6.6 million
  - 2023 Ryan White Part B Carryover: $5 million

- 2025-26: Total federal fund budget authority is projected to be $110.3 million (Table 1), $9.5 million (9.4 percent) higher than reported in the 2024-25 Budget Act. Federal fund budget authority includes the following estimated federal grant funding:
  - 2025 Ryan White Part B: $94.7 million
  - 2025 Ryan White Part B Supplemental: $9 million
  - 2025 ADAP Emergency Relief Funds (ADAP Shortfall Relief): $6.6 million

c) Federal Match – HRSA requires grantees to have HIV-related non-HRSA expenditures. OA meets the match requirement using ADAP Rebate Fund (Fund 3080) expenditures. California's HRSA match requirement for the 2024 Ryan White Part B grant budget period (April 1, 2024, through March 31, 2025) is $69.2 million.

V. Assumptions

New Assumptions

Amended Health and Safety Code (HSC) § 120960: Increase ADAP and PrEP-AP Income Limits from 500 Percent to 600 Percent of Federal Poverty Level (FPL)

Background: Effective June 24, 2015, revisions to the California HSC modified the income eligibility criteria for ADAP. Under the new guidelines, individuals with a Modified Adjusted Gross Income (MAGI) that does not exceed 500 percent of the FPL per year, based on family size and household income, are eligible. Prior to this change, the maximum qualifying income limit was $50,000 adjusted gross income based on individual income.

Description of Change: Statewide community partners advocated for an amendment to HSC § 120960. Their proposal aimed to raise the income limits for ADAP and PrEP-AP from 500 percent of the FPL to 600 percent of the FPL annually, based on family size and household income. This amendment expands eligibility, allowing more individuals to qualify for ADAP and PrEP-AP. SB 159 (Chapter 40, Statutes of 2024, Sec. 83 (a)(1)), authorized implementation to begin January 1, 2025, or as soon as technically feasible thereafter. The fiscal impact will be ongoing following the anticipated January 1, 2025, implementation due to the change to eligibility requirements.

Discretionary: No

Reason for Adjustment/ Change:

- Legislative requirement

Fiscal Impact and Fund Source(s): For 2024-25, the estimated fiscal impact to ADAP is $1.5 million (no rebate in 2024-25 due to the six-month delay in receipt of rebate following the January 2025 implementation) for 234 ADAP clients. For 2025-26, the estimate net fiscal impact to ADAP is $4.1 million ($10.4 million expenditures minus $6.3 million rebate) for 701 ADAP clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

For 2024-25, the estimated fiscal impact to PrEP-AP is $82,000 for 46 PrEP-AP clients. For 2025-26, the estimated fiscal impact to PrEP-AP is $586,000 for 137 PrEP-AP clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

ADAP Open Formulary

Background: ADAP's mission is to provide HIV-related prescription drugs to low-income PWH who have limited or no prescription drug coverage. ADAP directly

pays for the cost of medications that are covered on the California ADAP formulary (https://cdph.primetherapeutics.com/cms/cdph/static-assets/documents/formulary-and-documents/CDPH_Formulary.pdf) for people who only have ADAP coverage and pays for the copay for these medications for people who have primary comprehensive insurance (e.g., Covered California or Medicare). In the 1990s, the focus of ADAP was to pay for expensive HIV antiretroviral (ARV) medications to keep people alive. As HIV treatments have improved, PWH are living longer and healthier lives.

Medical needs have also shifted from a need to treat opportunistic infections that occur without HIV treatment to a need to treat medical conditions (e.g., high cholesterol) that are common in people as they age. Now 55.7 percent of PWH in California are 50 years of age or older and 15.6 percent are 65 years of age or older. As PWH have aged, their number of comorbid medical conditions has increased exponentially with a resultant need for additional medications to treat these additional medical conditions (e.g., diabetes, hypertension, hypothyroidism).

ADAP currently has a closed formulary meaning that medications are added one at a time after a review of the cost implications, approval from the CDPH Director, and approval in an annual estimate if the cost is significant. This model leads to a restrictive, basic level of coverage and the current ADAP formulary has 319 medications (including 47 HIV ARV medications). By contrast, an open formulary covers all Food & Drug Administration (FDA)-approved medications except for medications that have been specifically excluded from the formulary (usually due to high cost or safety issues).

Medi-Cal is an example of an open formulary as all FDA-approved drugs are added to the formulary and Medi-Cal decides which drugs to exclude from coverage. To quantify the difference in these formularies, the ADAP formulary is 13 pages long and the Medi-Cal formulary is 244 pages long. Many PWH move between Medi-Cal and ADAP depending on year-to-year changes in their income and life circumstances and these drastic differences in medication coverage leads to interruptions and undertreatment of common but serious medical conditions.

Thirteen states, including Illinois, Maryland, New Jersey, Washington, and Oregon, have already expanded their ADAP to an open formulary to help PWH in their states live longer and healthier lives. OA engaged in conversations with these states and determined that a shift to an open formulary is feasible for California's ADAP for three reasons:

1. These states report that, even with their expansion to an open formulary, HIV ARV medications still account for most of the cost to the program. The

amount of rebate generated from ARV medications has covered the cost of other medications in their open formularies.
2. People with high medication needs are also highly motivated to navigate to comprehensive insurance in which case ADAP only pays for copays on their medications. People with multiple comorbidities also require specialist medical appointments, diagnostic studies, and procedures that can only be paid for with comprehensive insurance.
3. These open ADAP formularies exclude the most expensive medications such as tumor necrosis factor (TNF)-alpha blockers, monoclonal antibodies, and recombinant human growth hormone. With the most expensive (non-HIV) medications excluded, these formularies can add access to a very wide range of medications within their allocated budgets.

In addition to the drugs listed in (3.), examples of highest cost medications that would be excluded are: botulinum toxin; compounded medications for infusion; gonadotropin; hyaluronic acid derivatives; synthetic growth hormone; antirheumatic antimetabolites; cosmetic medications; durable medical equipment; erectile dysfunction medications; female sexual dysfunction medications; fertility drugs; herbal medications; injectable muscle relaxants; nutrition supplements; vaccines/immunizing biologicals; weight loss medications; schedule II, III, IV and V controlled substances.

California has always been a leader in access to healthcare and HIV treatment. Opening the ADAP formulary to mirror the Department of Health Care Services (DHCS) Medi-Cal formulary (https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdf) will be another step toward healthier lives and improved health equity for PWH in California.

Description of Change: SB 159 (Chapter 40, Statutes of 2024, Sec. 83) authorizes CDPH to implement certain program enhancements, consistent with HSC § 120955, 120956, 120960, 120972, 120972.1, and 120972.2, to the extent that these activities are an allowable use of the ADAP Rebate Fund. This includes modifications to the ADAP formulary (from a closed to an open formulary) that are to begin January 1, 2025, or as soon as technically feasible thereafter. To provide sufficient time for discovery, coordination with ADAP's contractors, and seamless program implementation, ADAP identified FY 2025-26 as technically feasible. Following the FY 2025-26 implementation, the fiscal impact of changing to an open formulary will be ongoing and closely monitored as it is anticipated to result in an increase in expenditures.

Discretionary: No

Reason for Adjustment/ Change:

- Legislative requirement
- Ensure access for PWH to medications needed to treat common medical conditions that develop with aging (e.g., diabetes, hypertension, hypothyroidism)
- Align California's ADAP benefits with the level of medication coverage in other states
- Reduce treatment interruptions and undertreatment of common but serious medical conditions for PWH during transitions between Medi-Cal and ADAP
- Provide comprehensive approaches to chronic health to improve patient adherence and overall health outcomes

Fiscal Impact and Fund Source(s): There is no estimated fiscal impact for 2024-25. For 2025-26, the estimated net fiscal impact is $18.9 million ($26.9 million expenditures minus $8 million rebate) for 11,345 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Increasing Premium Threshold for Insurance Assistance Programs

Background: HRSA, which funds the RWHAP, encourages recipients to consider assisting clients by paying for premiums and/or cost-sharing, if cost-effective. RWHAP legislation allows ADAP the option of purchasing or maintaining health care coverage for ADAP clients instead of paying solely for HIV medications. This same legislation states that an ADAP can purchase health care coverage if the costs of the health insurance or plans to be purchased or maintained do not exceed the costs of otherwise providing therapeutics. ADAP must determine if the cost of paying for the health care coverage is cost-effective in the aggregate versus paying for the full cost for medications for all clients. The current premium threshold, $1,938, was last updated in 2011.

ADAP calculated the maximum monthly premium amount that is cost effective to pay private insurance premiums, drug costs (drug deductibles, co-pays, and/or co-insurance with rebate), medical out-of-pocket costs, and administrative costs compared to the full price of ADAP Medication-only drug costs with rebate and administration costs. Based on this analysis, $2,996, was identified as a premium threshold.

Description of Change: SB 159 (Chapter 40, Statutes of 2024, Sec. 83) authorizes CDPH to implement certain program enhancements, consistent with HSC § 120955, 120956, 120960, 120972, 120972.1, and 120972.2, to the extent that these activities are an allowable use of the ADAP Rebate Fund. Program enhancements include an increase to the cap on premium payments from $1,938 to $2,996 per month, and are to begin January 1, 2025, or as soon as technically feasible thereafter. ADAP identified January 1, 2025, as technically feasible to

increase the premium threshold from $1,938 per month to $2,996, the fiscal impact of which will be ongoing following the anticipated January 1, 2025, implementation.

Discretionary: No

Reason for Adjustment/ Change:
- Legislative requirement

Fiscal Impact and Fund Source(s): For 2024-25, the estimated fiscal impact is $1.8 million for 219 clients. For 2025-26, the estimated fiscal impact is $3.5 million for 219 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Early Action Package: Annual Allocation for Three Years beginning July 1, 2024

Background: SB 159 (Chapter 40, Statutes of 2024, Sec. 83) authorizes CDPH to spend up to $23 million from the ADAP Rebate Fund to implement various program enhancements, consistent with HSC § 120955, 120956, 120960, 120972, 120972.1, and 120972.2, to the extent that these activities are an allowable use of the ADAP Rebate Fund, as part of the Early Action Package approved in the Budget Act of 2024.

Description of Change: Per SB 159, a portion of the $23 million will fund Sec. 83. (a)(5), Harm Reduction Supply Clearinghouse, to fund HIV prevention supplies to California syringe access programs for three years beginning July 1, 2024.

Discretionary: No

Reason for Adjustment/ Change:
- Legislative requirement

Fiscal Impact and Fund Source(s): For 2024-25, the fiscal impact is $10 million. For 2025-26, the fiscal impact is $10 million. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Employer-Based Health Insurance Premium Payment (EB-HIPP) Program Expansion to ADAP Clients who are not the Primary Insured

Background: The EB-HIPP program is a subsidy program that provides premium assistance for an ADAP client's portion of their employer-based insurance premiums. EB-HIPP pays the client's portion of their monthly medical and dental premiums, if eligible. If a vision premium is included in the medical or dental

premium, the client will have their vision premiums subsidized. Currently, the ADAP client must be the primary on the employer's coverage to be eligible for EB-HIPP.

Description of Change: Effective July 1, 2025, the EB-HIPP program will expand program benefits to include paying the premiums for an ADAP client who is not the primary insured but is instead enrolled in employer-based insurance where their spouse, registered domestic partner, or parent is the primary insured.

Discretionary: Yes

Reason for Adjustment/ Change:

- Encourage clients to enroll in cost-saving insurance coverage
- Provide more plan options to clients enrolled on their spouse's plan
- Allow for continuity of care if client has established coverage through spouse's insurance

Fiscal Impact and Fund Source(s): There is no estimated fiscal impact for 2024-25. For 2025-26, the estimated savings is $128,000 for 31 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Payments for Medicare Part B Premiums

Background: HRSA permits use of RWHAP funds to pay for Medicare Part B premiums. However, clients receiving Social Security benefits cannot stop their Medicare Part B premium deductions from their benefits. As a result, ADAP does not have a mechanism to make Medicare Part B payments on behalf of clients. Those who do not have Medicare Part B premium deductions from their Social Security benefits, will have their Medicare Part B premiums paid directly.

Description of Change: Effective July 1, 2025, ADAP requests the authorization to make direct payments to clients to reimburse monthly Medicare Part B premiums for those who have Medicare Part B deductions from the Social Security benefits.

Discretionary: Yes

Reason for Adjustment/ Change:

- Provide mechanism for payments that are approved, but not currently payable
- Continuity of premium assistance when transitioning from private insurance to Medicare
- Encourage clients to complete timely re-enrollments and update contact information

Fiscal Impact and Fund Source(s): There is no estimated fiscal impact for 2024-25. For 2025-26, the estimated fiscal impact is $4.7 million for 3,950 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Payment of Medicare Part B Medical Out-of-Pocket Costs

Background: Clients eligible for Medicare Premium Payment Program (MPPP) can submit medical out-of-pocket claims for costs associated with Medicare Part B. To qualify for MPPP, ADAP must pay Medicare Part C or Part D premiums. Claims must include proof that Medicare was billed as the primary payer.

Description of Change: Effective July 1, 2025, clients enrolled in MPPP with Medicare Part B as their only qualifying premium assistance will be able to submit Medicare Part B medical out-of-pocket claims to the ADAP Medical Benefits Manager.

Discretionary: Yes

Reason for Adjustment/ Change:

- Provide comprehensive medical coverage for Medicare clients regardless of their Part C or Part D plan
- Ensure continuity of medical out-of-pocket benefits when transitioning from private insurance to Medicare
- Part B medical out-of-pocket expansion coincides with payment of Part B premiums

Fiscal Impact and Fund Source(s): There is no estimated fiscal impact for 2024-25. For 2025-26, the estimated fiscal impact is $370,000 for 650 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Medicare Part D: Out-of-Pocket Prescription Cap

Background: Medicare Part D is a program specifically designed to address the prescription drug needs of eligible individuals. Depending on the benefit type, Medicare Part D plans can include premiums, deductibles, co-payments, and/or co-insurance.

True out-of-pocket expenditures for Medicare Part D is the amount a beneficiary must spend in a calendar year on Medicare Part D covered drugs to reach the Medicare Part D catastrophic coverage threshold. The gap in Medicare Part D coverage starts when total drug costs reach a designated level and ends when expenditures for medications reach the catastrophic coverage threshold. ADAP funds can be used to cover the costs of Medicare D premiums, deductibles, co-payments, and medications on the ADAP formulary.

Description of Change: The federal Inflation Reduction Act (IRA) of 2022 makes improvements to Medicare, increasing accessibility and affordability of prescription drugs for Medicare enrollees. Effective January 1, 2025, Medicare will begin placing an annual cap on out-of-pocket costs under the Medicare Part D program starting at $2,000, which is designed to make prescription drugs more affordable, improve health outcomes, and reduce costs for enrollees.

The annual out-of-pocket cap for Medicare Part D and Medicare Advantage prescription drug cost will reduce the number of cost-sharing payments that will be made by ADAP's on behalf of Medicare beneficiaries enrolled in their programs and, consequently, the number of rebate claims that can be submitted to manufacturers.

Discretionary: No

Reason for Adjustment/ Change:

- Federal requirement

Fiscal Impact and Fund Source(s): For 2024-25, the estimated savings is $2.7 million (no rebate in 2024-25 due to the six-month delay in receipt of rebate following the January 2025 implementation) for 3,819 clients. For 2025-26, the estimated net fiscal impact is $9.8 million ($5.1 million expenditure savings minus $14.9 million loss rebate) for 3,949 clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

PrEP Medication: Lenacapavir

Background: Lenacapavir (Sunlenca) is an HIV capsid inhibitor that was developed as a long-acting injectable ARV treatment. Lenacapavir is administered via subcutaneous injection every six months, providing PWH with a very long-acting treatment option that was safe and well tolerated in clinical trials.

On December 22, 2022, lenacapavir (Sunlenca) was approved by the FDA for HIV treatment. On April 25, 2023, it was added to the ADAP formulary. Lenacapavir is now being evaluated in five phase three (III) HIV prevention trials as a possible PrEP medication and results from these trials could be available in late 2024/early 2025.

Description of Change: OA will add lenacapavir to the PrEP-AP formulary for use in select situations where patients cannot access lenacapavir through an insurance plan or the manufacturer's assistance program. Utilization of lenacapavir is anticipated to be at a volume that is not cost neutral and is

projected to have a moderate fiscal impact, commencing in FY 2025-26. The fiscal impact accounts for the cost of the medication and administration.

Discretionary: Yes

Reason for Adjustment/ Change:

- Drug under development specifically indicated for the prevention of HIV infection
- Per HSC § 120972, eligible PrEP-AP persons have access to drugs listed on the ADAP drug formulary
- Reduce structural and administrative barriers often resulting in long wait times, denial of coverage, and ultimately failure to initiate treatment
- Alleviate barriers and improve client access to new injectable PrEP treatments available

Fiscal Impact and Fund Source(s): There is no fiscal impact for 2024-25. For 2025-26, the estimated fiscal impact is $3.2 million for 200 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Gilead's Plans to Discontinue Patient Assistance Program for Truvada

Background: PrEP-AP relies on clients' co-enrollment in the Gilead Advancing Access Patient Assistance Program (PAP), which covers the cost of brand name PrEP medications for PrEP-AP clients, specifically Truvada and Descovy. A generic Truvada has become available and Gilead plans to discontinue their brand name Truvada PAP. Should this occur, PrEP-AP will need to include Truvada (generic) in the PrEP-AP formulary and provide medication coverage for uninsured clients. The Descovy PAP is expected to continue, there is no generic option for Descovy. Descovy is not clinically indicated for HIV PrEP for some patients (e.g., people whose risk of HIV exposure is from vaginal sex or from injection drug use) so it is not possible for all patients in the Truvada PAP to transition to the Descovy PAP.

Description of Change: On September 20, 2024, OA was informed of Gilead's plans to discontinue their brand name Truvada PAP, although the implementation date was not yet confirmed. Since then, Gilead has announced and sent notices to providers and clients nationwide that they would be ending enrollment into the Gilead PAP for Truvada on December 31, 2024, and would end the program for existing clients on January 31, 2025, with an exception for clients assigned female at birth who can remain on the program until July 31, 2025. Despite community and advocate push-back and OA communications with Gilead representatives, it appears Gilead will not be delaying or reneging their decision to end the

program. PrEP-AP requests to add Truvada (generic) to the PrEP-AP formulary for uninsured clients to ensure a seamless transition for uninsured clients.

Discretionary: Yes

Reason for Adjustment/ Change:

- Clients no longer have access to Truvada PAP
- PrEP-AP will need to cover the cost of generic Truvada for uninsured clients whose preferred PrEP medication is Truvada

Fiscal Impact and Fund Source(s): For 2024-25, the estimated fiscal impact is $128,000 for 545 clients. For 2025-26, the estimated fiscal impact is $257,000 for 545 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Increase in Federal Funds: 2024 Ryan White Part B Supplemental

Background: The HRSA Ryan White Part B Supplemental grant develops and/or enhances access to a comprehensive continuum of high-quality care and treatment services for low-income individuals living with HIV. The amount of each award is based on submitted data demonstrating the severity of the HIV epidemic in the applicant's state/territory, comorbidities, cost of care, and service needs of emerging populations.

The following table displays historical application amounts for which OA applied, total funds awarded per grant budget period, and total ADAP Local Assistance received per grant budget period.

Table 4: Ryan White Part B Supplemental Funds

Grant Budget Period	Application Amount	Total Funds Awarded	Total Local Assistance
2020 (09/30/2020 – 09/29/2021)	$10,000,000	$2,628,306	$2,567,306
2021 (09/30/2021 – 09/29/2022)	$9,000,000	$1,941,558	$1,916,558
2022 (09/30/2022 – 09/29/2023)	$9,000,000	$2,250,912	$2,250,912
2023 (09/30/2023 – 09/29/2024)	$9,000,000	$5,337,315	$5,337,315
2024 (09/30/2024 – 09/29/2025)	$9,000,000	$9,000,000	$9,000,000

Description of Change: On April 29, 2024, OA applied for the competitive 2024 Ryan White Part B Supplemental grant. OA requested the maximum amount of $9 million, all of which is designated for ADAP Local Assistance to be used in 2024-25. On August 19, 2024, OA received the notice of award for the 2024 Ryan White Part B Supplemental grant in the amount of $9 million, all ADAP Local Assistance.

Discretionary: Yes

Reason for Change/Adjustment:
- Competitive funding opportunity
- Prior funding does not guarantee funding will be provided in the future

Fiscal Impact and Fund Source: Increase of $3.7 million in Local Assistance for 2024-25 and 2025-26. The fund impacted is the Federal Trust Fund (Fund 0890).

Increase in Federal Funds: 2023 Ryan White Part B Grant Carryover

Background: The HRSA Ryan White Part B grant is a non-competitive grant and the largest of the three federal grants for which ADAP receives funding. Grant funding is appropriated in five, 12-month grant budget periods that run from April 1 to March 31. Within the five-year funding cycle, funding from year to year is provided if the program remains eligible and submits all reporting requirements in a timely manner. Funding from the Ryan White Part B grant that is not fully expended by the end of the budget period can be carried over to the next budget period with approval from HRSA.

Description of Change: At the end of August 2024, OA closed out the 2023 Ryan White Part B grant with HRSA and applied for carryover funding of unobligated funds from the 2023 grant budget period (April 1, 2023, through March 31, 2024). Upon closure of the grant, the amount of unspent funding was determined, for which the ADAP Branch applied. The request for HRSA approval was due the end of August 2024.

On September 11, 2024, OA received the notice of award for carryover totaling $5 million in ADAP Local Assistance. Carryover funding is anticipated to be spent in 2024-25.

Discretionary: Yes

Reason for Change/Adjustment:
- Fully leverage federal funding

Fiscal Impact and Fund Source: Increase of $5 million in Local Assistance for 2024-25. The fund impacted is the Federal Trust Fund (Fund 0890).

Existing Assumptions

ADAP Pilot Program for Jails

Background: Prior to 2008, 36 local county jails participated in ADAP to provide medication assistance to qualifying detainees. The program was terminated in 2008 due to the elimination of funding from the State's General Fund. Subsequently, in 2018, HRSA released Policy Clarification Notice (PCN) 18-02, which permitted the use of HRSA funds for individuals who are detained in a county jail and are not yet convicted of a crime or are not covered by federal or state health benefits. After the PCN release, Orange County asked CDPH to provide ADAP services at their county jail.

Providing ADAP services to jail detainees expands outreach to a vulnerable population while supporting continuity of care for those navigating the judicial system. Incarcerated clients who meet ADAP eligibility requirements can enroll in ADAP with the help of a certified enrollment worker from the county jail, which must be approved as an enrollment site. New and existing clients can access medication(s) at the jail pharmacy, thus maximizing potential adherence to medicinal regimens. Additionally, the jail pharmacy can provide a prescription refill to clients scheduled for release, so that the client has a supply of medication available until they can access ADAP services through a community enrollment site.

In response to Orange County's request, OA initiated a pilot program in 2021-22 with the Orange County jail. OA, in consultation with the Department of Finance, is expanding the pilot program to other interested county jails after careful consideration of the impact to the ADAP Rebate Fund, both in the short and long term.

OA met with the other interested county jails in the summer of 2022 to understand how they address the transitional needs of PWH who have been incarcerated. OA determined whether each respective jail would be a suitable ADAP jail enrollment site. Prior to becoming an enrollment site, interested county jails will need to submit a new Enrollment Site Application, begin the contracting process with OA, be added to the Pharmacy Benefits Manager Pharmacy Network, and complete the new enrollment worker training. Clients will not be enrolled until a contract is in place and the enrollment worker training is completed.

The 2022-23 May Revision approved seven counties which expressed interest: Orange, Los Angeles, Marin, Riverside, San Francisco, San Luis Obispo, and Siskiyou. OA has a contract in place with Orange County and continued to conduct outreach to the remaining six counties.

The 2023-24 November Estimate approved addition of three interested counties in conjunction with the seven aforementioned counties: San Bernardino, San Joaquin, and Tuolumne. Additional funding was requested in 2022-23 for the seven counties, and for both the original seven counties and additional three (ten counties total) in 2023-24 following updated information from the counties.

With Orange County's contract in place since 2021-22, outreach efforts continued for five remaining counties (Los Angeles, Riverside, San Francisco, San Joaquin, and Tuolumne); four counties withdrew interest (Marin, San Bernardino, San Luis Obispo, and Siskiyou). As contracts for the remaining counties were not anticipated to be executed until possibly July 2023, the 2022-23 fiscal impact decreased from the 2023-24 November Estimate, reflecting only Orange County expenditures in the 2023-24 May Revision. The 2023-24 fiscal impact reflected six counties total which, due to updated county interest and client count data, decreased in the 2023-24 May Revision compared to the 2023-24 November Estimate.

On July 1, 2023, the ADAP enrollment site contract for San Joaquin County was executed. Los Angeles, Riverside, and San Francisco counties submitted enrollment site applications and proceeded with the contract process. Tuolumne County, the last of the previously approved interested counties, anticipated submitting a completed ADAP enrollment site application after conclusion of internal discussions and prior to the fall of 2023.

Following the end of the Public Health Emergency, ADAP resumed pre-COVID-19 outreach efforts to the remaining 48 counties for renewed interests in the pilot program and a 2024-25 implementation. A total of 25 counties responded to ADAP's outreach. Four of the 25 counties confirmed interest in becoming an ADAP enrollment site, the fiscal impact of which is included in 2024-25: Contra Costa, Sacramento, San Mateo, and Tulare. The remaining 21 counties confirmed they are not interested or unable to participate at this time.

As communicated in the 2024-25 May Revision, outreach efforts continued with Contra Costa, Sacramento, San Mateo, Tulare, and Tuolumne counties; these five counties remained interested but had not submitted ADAP enrollment site applications. No new counties are on record as having expressed interest in becoming ADAP enrollment sites. The 2024-25 May Revision reflected a decrease in projected clients following receipt of a few months of actual client data, subsequently decreasing projected expenditures compared to the 2024-25 November Estimate.

Description of Change: Five counties withdrew interest or are unable to participate in the pilot program for jails for FY 2024-25: Contra Costa, San Mateo, Sacramento, Tulare, and Tuolumne. Four counties have approved enrollment site

locations and OA continues outreach to encourage enrollment and provide training: Los Angeles, Riverside, San Francisco, and San Joaquin. Orange County remains the only active enrollment site with clients enrolled. Compared to the 2024-25 May Revision, the 2025-26 November Estimate projects a decrease in projected expenditures.

Discretionary: Yes

Reason for Adjustment/Change:

- HRSA PCN 18-02, which permits the use of funds for individuals who are currently detained in a county jail
- Treatment and suppression of HIV/AIDS and HIV/AIDS-related opportunistic infections among high-risk individuals
- Effective outreach to underserved populations
- Continuity of care

Fiscal Impact and Fund Source(s): For 2024-25, the estimated net fiscal impact of the remaining five approved pilot counties (Orange, Los Angeles, Riverside, San Francisco, and San Joaquin) with staggered implementations is $4.3 million ($6.1 million expenditures minus $1.8 million rebate) for 447 eligible clients. For 2025-26, the estimated net fiscal impact of the same five approved pilot counties is $3 million ($7.2 million expenditures minus $4.2 million rebate) for 563 eligible clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

Full Scope Medi-Cal Coverage for Justice Involved Individuals

Background: On January 26, 2023, California became the first state in the nation to be approved to offer a targeted set of Medicaid (Medi-Cal in California) services to youth and adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release. Currently, Medi-Cal services are generally available only after release from incarceration. Through a federal Medicaid 1115 demonstration waiver, DHCS will establish a coordinated community reentry process that will assist people leaving incarceration to connect to the physical and behavioral health services they need upon release. As codified by Assembly Bill (AB) 133 (Chapter 143, Statutes of 2021), the California Advancing and Innovating Medi-Cal (CalAIM) Initiative's pre-release eligibility and enrollment went live on January 1, 2023, and will help ensure that, if determined eligible, all incarcerated adults and youths within County Correctional Facilities and County Youth Correctional Facilities have access to needed Medi-Cal services upon their re-entry into the community.

Historically, Californians in prisons, jails, and juvenile detention facilities have difficulty accessing health care services after they have been released and are

transitioning back into their communities, including PWH. As outlined in Penal Code section 4011.11, the board of supervisors, in consultation with the county sheriff and chief probation officer, respectively, shall designate an entity or entities to assist both county jail inmates and juvenile inmates with the application process for health insurance affordability programs consistent with federal requirements. AB 133 allows jails to help connect an individual to a community-based Medi-Cal provider 90 days prior to their release to ensure they can continue care and treatment once returning to the community. Each county is expected to implement at different points in time as they work with Medi-Cal to create an implementation plan for Medi-Cal services within their respective county jails. Starting no sooner than April 2024, individuals would be able to receive up to 90 days of Medi-Cal coverage prior to being released from a public institution, including medication coverage.

Through ADAP's pilot program for jails, ADAP provides medication assistance to qualifying detainees at local county jails. ADAP does not provide services for individuals incarcerated in youth correctional facilities or adults in state prisons.

Individuals enrolled in ADAP's pilot program for jails who are due to be released from jail may be enrolled into Medi-Cal pre-release services 90 days prior to release, if eligible. ADAP's pilot program for jails is currently implemented in Orange and San Joaquin County.

Individuals who are granted pre-release services will be disenrolled from ADAP by their Enrollment Worker to safeguard ADAP as the payor of last resort. ADAP will back-bill Medi-Cal for dual enrolled clients via the established Medi-Cal Eligibility Data System (MEDS) match process. OA anticipates a gradual uptake of ADAP clients found on the MEDS match which will result in a cost savings for ADAP as Medi-Cal will be back-billed for these services.

On December 8, 2023, OA was informed that DHCS pre-release services commencing April 1, 2024, are postponed until October 1, 2024. At that time, each correctional facility will have a two-year period to implement the 90-day pre-release services, between October 1, 2024, and September 20, 2026. Due to the postponed implementation, the 2024-25 May Revision reflects a decrease in projected clients, subsequently decreasing projected savings compared to the 2024-25 November Estimate.

Description of Change: The 2025-26 November Estimate client count and cost per client data was refined and reflects a decrease compared to the 2024-25 May Revision.

Discretionary: No

Reason for Adjustment/Change:

- Federal Medicaid 1115 demonstration waiver
- Legislative requirement

Fiscal Impact and Fund Source(s): For 2024-25, the estimated net savings is $163,000 ($193,000 savings minus $30,000 rebate) for 95 clients. For 2025-26, the estimated net savings is $1.6 million ($2.1 million savings minus $537,000 rebate) for 281 clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

PrEP and PEP Initiation and Retention Initiative (PPIRI)

Background: ADAP received statutory and budgetary authority through the 2016 Budget Act (Chapter 23, Statutes of 2016) to provide services to HIV-negative persons at risk for acquiring HIV. Statutory authority is codified in HSC § 120972 and allows OA to implement PrEP-AP to assist both insured and uninsured individuals who meet eligibility requirements. PrEP-AP helps with PrEP-related and non-occupational PEP-related medical out-of-pocket costs, and access to medications on the PrEP-AP formulary for the prevention of HIV and treatment of sexually transmitted infections.

In 2021, AB 133 (Chapter 143, Statutes of 2021) added language allowing allocation of ADAP funds for PrEP and PEP navigation and retention. AB 133 allows ADAP to fund local health departments and community-based organizations, to the extent that funds are available, for PrEP and PEP navigation and retention coordination and related services. Funded activities may include outreach and education; community messaging; assistance with applying for and retaining health coverage; assistance with enrollment in PrEP and PEP financial assistance programs; care coordination and adherence support; financial assistance for transportation costs; and linkage to behavioral health, substance use, housing, and other social service programs.

This project was named the PrEP and PEP Initiation and Retention Initiative (PPIRI) to avoid confusion with CDPH/OA HIV Prevention Branch PrEP Navigation projects. Planning and development of a competitive solicitation is underway. Stakeholder engagement was held in early 2022 to assess capability, interest, and need.

The 2023-24 November Estimate anticipated the competitive procurement to commence in the fall of 2022, and agreements with approved entities would commence in early 2023. However, as communicated in the 2023-24 May Revision, the competitive solicitation was released on January 17, 2023, and agreements with approved entities did not commence until summer 2023. Subsequently, the fiscal impact affected fiscal years 2023-24, instead of 2022-23.

The 2024-25 November Estimate communicated the PPIRI intent to fund announcement was released on March 17, 2023. Fewer applicants than expected applied to the PPIRI competitive procurement resulting in a reduction in the number of awards and reducing the fiscal impact. In addition, the 2023-24 May Revision anticipated the fiscal impact to commence in early 2023-24; however, due to contract development delays the anticipated date of commencement was January 1, 2024.

The 2024-25 May Revision communicated that minor administrative corrections generated a slight delay in implementation. In early spring of 2024, PPIRI agreements were expected to commence with a total of 24 approved entities: AltaMed Health Services Corporation; Altura Centers for Health; Asian Health Services; Blessing Community Health Center; County of Butte; California State University, East Bay Foundation, Incorporated (Inc.); Central Neighborhood Health Foundation; Community Medical Centers, Inc.; Charles R. Drew University of Medicine and Science; Foothill AIDS Project; East Bay AIDS Center Medical Group, Inc.; Fresno Community Hospital and Medical Center; Clinicas de Salud del Pueblo, Inc., doing business as Innercare; County of Sacramento, Department of Health Services; San Bernardino County; County of San Diego; San Francisco AIDS Foundation; Centro de Salud de la Comunidad de San Ysidro, Inc.; County of Santa Cruz; Sunburst Projects; The Source Lesbian, Gay, Bisexual, and Transgender Plus Center, Inc.; The Wall – Las Memorias; Keck Medical Center of University of Southern California; and County of Yolo.

Description of Change: On March 26, 2024, the first agreement was fully executed. On April 15, 2024, Blessing Community Health Center withdrew from the award cycle, leaving a total of 23 approved entities compared to the 2024-25 May Revision. As of July 3, 2024, all the agreements for the 23 awards are fully executed.

Discretionary: Yes

Reason for Adjustment/Change:

- Legislation was codified allowing CDPH/OA to fund local health departments and community-based organizations, to the extent that funds be available, for PrEP and PEP navigation and retention coordination and related services

Fiscal Impact and Fund Source(s): For 2024-25, the total estimated fiscal impact is $7.6 million ($5.1 million for 23 approved entities and $2.5 million for 229 new PrEP-AP clients, inclusive of medication and medical-out-of-pocket costs). For 2025-26, the total estimated fiscal impact is $12.2 million ($5.1 million for 23 approved entities and $7.1 million for 458 new PrEP-AP clients, inclusive of medication and

medical-out-of-pocket costs). The fund impacted is the ADAP Rebate Fund (Fund 3080).

MPPP Expansion to Dental and Vision

Background: The OA Health Insurance Premium Payment (OA-HIPP) program provides dental and vision premium coverage for eligible clients. Once a client becomes Medicare eligible, they no longer qualify for dental and vision premium assistance through HIPP. MPPP provides Medicare Part C and Part D premium assistance, and Medigap premium assistance. Medicare clients must pay for their own dental and vision policies due to MPPP not covering these plans.

In the 2024-25 November Estimate, ADAP requested to expand coverage to dental and vision premiums for MPPP eligible clients. Effective July 1, 2024, MPPP began offering dental and vision premium assistance to MPPP clients to allow the continuity of holistic care for clients that become Medicare eligible. Extending the same level of premium assistance from the HIPP program to MPPP ensures consistent health coverage for all client groups.

The 2024-25 May Revision client count and cost per client per month data was refined; however, this did not pose a significant change compared to the 2024-25 November Estimate.

Description of Change: The 2025-26 November Estimate client count and cost per client data was refined and reflects a decrease compared to the 2024-25 May Revision.

Discretionary: Yes

Reason for Adjustment/Change:

- Allow for continuity of care when transitioning from private insurance to Medicare
- Provide clients opportunity for holistic health coverage
- Medicare does not provide dental coverage, clients currently responsible for premiums of additional plan

Fiscal Impact and Fund Source(s): For 2024-25, the estimated fiscal impact is $101,000 for 250 clients. For 2025-26, the estimated fiscal impact is $302,000 for 500 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Paying above Medicare Part D Benchmark Premiums

Background: Medicare provides free prescription drug coverage through Medicare Part D benchmark plans for clients that are deemed eligible or apply

through Medicare's low-income subsidy (LIS) program. ADAP clients are strongly encouraged to enroll in a Medicare Part D Benchmark plan if they are eligible. Clients enrolled in a benchmark plan who are deemed full LIS are not eligible to enroll in MPPP as the subsidy provided covers the premium and deductible of the benchmark plan.

Beginning in 2024, Medicare is eliminating partial LIS and extending 100 percent subsidy benefits to eligible clients. As a result, more ADAP clients will qualify for benchmark plans and be ineligible for the MPPP. However, the coverage of benchmark plans and plan selection is limited compared to non-benchmark plans. For example, there are an average of 22 Medicare Part D plans available for non-benchmark clients to select from compared to four benchmark plans available for benchmark eligible clients. The MPPP benefit also provides coverage of Medicare Part B out-of-pocket costs and Medicare supplemental premiums and currently clients deemed full LIS are not able to access these benefits.

In the 2024-25 November Estimate, ADAP requested to expand MPPP eligibility to clients that are deemed eligible for free Medicare Part D and qualify for 100 percent LIS, effective July 1, 2024. ADAP will pay for the remaining Medicare Part D premium after subsidies are applied. Clients will also be eligible for Medicare Part B out-of-pocket claims, Medicare supplemental premium coverage, and selection of any available Medicare Part D plan. Expanding MPPP will provide clients more plan choices and an opportunity for more comprehensive health coverage.

The 2024-25 May Revision client count and cost per client per month data was refined; however, this did not pose a significant change compared to the 2024-25 November Estimate.

Description of Change: To provide sufficient time for discovery, coordination with ADAP's contractors, and seamless program implementation, OA will start implementing processes for paying over Medicare Part D Benchmark premiums in early 2025 instead of July 1, 2024, as was initially communicated in the 2024-25 May Revision, thus decreasing expenditures in the 2025-26 November Estimate.

Discretionary: Yes

Reason for Adjustment/Change:

- Benchmark plan choices are severely limited and continue to decrease
- Injectable drugs, such as Cabenuva, can be billed to Medicare Part B
- Ineligible for Part B medical out-of-pocket costs if not enrolled in MPPP
- MPPP provides more comprehensive health coverage options

Fiscal Impact and Fund Source(s): For 2024-25, the estimated fiscal impact is $23,000 for 131 clients. For 2025-26, the estimated fiscal impact is $175,000 for 394 clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

Increase in Federal Funds: 2024 Ryan White Part B Grant

Background: The HRSA Ryan White Part B grant is a non-competitive grant and the largest of the three federal grants from which the ADAP receives funding. Grant funding is appropriated in five, 12-month grant budget periods that run from April 1 to March 31. Within the five-year funding cycle, funding from year to year is provided if the program remains eligible and submits all reporting requirements in a timely manner.

On November 15, 2023, OA applied for the 2024 Ryan White Part B grant, the third year of the latest five-year funding cycle. The total funding requested in the grant application was $139.9 million, of which $93.3 million was designated ADAP Local Assistance.

Description of Change: On March 19, 2024, OA received a notice of partial award in the amount of $59.1 million, of which $42.7 million was designated to the ADAP Branch; however, receipt of a partial award did not allow for OA to identify the Local Assistance component of the $42.7 million.

On June 21, 2024, OA received the remaining notice of award in the amount of $80.8 million, thus bringing the total award to $139.9 million, of which $94.7 million is ADAP Local Assistance.

Discretionary: Yes

Reason for Change/Adjustment:

- Fully leverage federal funding

Fiscal Impact and Fund Source: Increase of $1.4 million in Local Assistance for 2024-25 and 2025-26. The fund impacted is the Federal Trust Fund (Fund 0890).

Increase in Federal Funds: 2024 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Background: The HRSA ADAP Emergency Relief Funds grant (ADAP Shortfall Relief grant) is intended for states/territories that demonstrate the need for additional resources to prevent, reduce, and/or eliminate ADAP waiting lists through implementation of cost-containment measures. OA cost-containment measures

include maintaining data match agreements to safeguard ADAP as the payer of last resort.

The following table displays the historical grant application amounts for which OA has applied, and the total funds awarded per grant budget period:

Table 5: ADAP Emergency Relief Funds (Shortfall Relief) Grant		
Grant Budget Period	Application Amount	Total Funds Awarded
2020 (04/01/2020 – 03/31/2021)	$10,000,000	$6,537,311
2021 (04/01/2021 – 03/31/2022)	$7,000,000	$5,307,130
2022 (04/01/2022 – 03/31/2023)	$7,000,000	$5,850,650
2023 (04/01/2023 – 03/31/2024)	$7,000,000	$6,433,858
2024 (04/01/2024 – 03/31/2025)	$7,000,000	$6,584,874

Description of Change: On October 18, 2023, OA applied for the competitive 2024 ADAP Emergency Relief Funds grant. The total funding requested in the grant application was the maximum amount of $7 million, all of which is designated ADAP Local Assistance. On February 23, 2024, OA received a partial notice of award totaling $2.2 million and on May 15, 2024, OA received the final notice of award totaling $4.4 million, bringing the total funds awarded to $6.6 million, all of which is ADAP Local Assistance.

Discretionary: Yes

Reason for Change/Adjustment:
- Competitive funding opportunity
- Prior funding does not guarantee future funding

Fiscal Impact and Fund Source: Increase of $4.4 million in Local Assistance for 2024-25 and 2025-26. The fund impacted is the Federal Trust Fund (Fund 0890).

Discontinued Assumptions

HIV Medication: Lenacapavir (Sunlenca)

Why is Change Needed/ Reason for Adjustment: This assumption will be discontinued since it was previously approved in the 2024-25 May Revision and included in the base estimate. The medication was added to the ADAP formulary on April 25, 2023.

PrEP Medication: Cabotegravir (Apretude)

Why is Change Needed/ Reason for Adjustment: This assumption will be discontinued since it was previously approved in the 2024-25 May Revision and included in the base estimate. The medication was added to the ADAP formulary on December 21, 2023.

Expansion of Medi-Cal for All Income-Eligible Californians

Why is Change Needed/ Reason for Adjustment: This assumption will be discontinued since it was previously approved in the 2024-25 May Revision and included in the base estimate. Effective January 1, 2024, undocumented ADAP clients ages 26 through 49 with income below 138 percent FPL are referred to Medi-Cal and screened during initial enrollment and re-enrollment.

Medi-Cal Expansion: Asset Limit Changes

Why is Change Needed/ Reason for Adjustment: This assumption will be discontinued since it was previously approved in the 2024-25 May Revision and included in the base estimate. Effective January 1, 2024, DHCS eliminated the asset limit entirely, and ADAP clients who previously did not qualify for non-MAGI Medi-Cal based on the previous asset test are referred to Medi-Cal at initial enrollment and re-enrollment.

Client Navigation Outreach

Why is Change Needed/ Reason for Adjustment: This assumption will be discontinued while the needs assessment/gap analysis outlined in SB-159, Sec.83(a)(6), is conducted and findings are made available. Will reintroduce in a future ADAP Estimate, pending the outcome of the needs assessment/gap analysis.

Decrease in Federal Funds: 2023 Ryan White Part B Grant

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2023-24 has ended and funding has been expended.

Increase in Federal Funds: 2023 Ryan White Part B Supplemental

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2023-24 has ended and funding has been expended.

Increase in Federal Funds: 2023 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant):

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2023-24 has ended and funding has been expended.

Increase in Federal Funds: 2022 Ryan White Part B Grant Carryover

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2023-24 has ended and funding has been expended.

VI. Expenditure Details

Tables 6 through 11, starting on the next page, break down caseload and expenditures by client group and service type.

TABLE 6: November Estimate Caseload and Variable Expenditures; Current Year 2024-25						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	9,870	28.8%	$228,013,305	$0	$0	$228,013,305
Medi-Cal SOC	79	0.2%	$799,595	$0	$0	$799,595
Private Insurance*	9,832	28.7%	$27,535,489	$77,572,049	$2,817,240	$107,924,777
Medicare*	7,155	20.9%	$14,499,291	$5,986,309	$396,570	$20,882,170
PrEP-AP	7,307	21.3%	$18,113,885	$0	$2,414,292	$20,528,177
SUBTOTAL	**34,243**	**100.0%**	**$288,961,564**	**$83,558,358**	**$5,628,102**	**$378,148,023**
Admin: ADAP	-	-	$2,468,433	$2,036,680	$1,041,799	$5,546,912
Admin: PrEP-AP	-	-	$0	$0	$5,361,163	$5,361,163
Admin: Enrollment	-	-	$0	$0	$0	$7,825,500
HMS	-	-	-$16,373,540	$0	$0	-$16,373,540
Early Action Package**	-	-	$0	$0	$0	$10,000,000
TOTAL	**34,243**	**100.0%**	**$275,056,457**	**$85,595,037**	**$12,031,064**	**$390,508,058**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
* Subgroup of 11,965 clients receiving assistance for premium payments and medical-out-of-pocket costs.
** Early Action Package expenditure accounts for Harm Reduction. Expenditures for increasing the FPL to 600 percent, ADAP Open Formulary, and increasing the premium threshold are accounted for in their respective client groups and service type expenditures.

TABLE 7: 2024 Budget Act Caseload and Variable Expenditures						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	8,275	26.2%	$218,512,685	$0	$0	$218,512,685
Medi-Cal SOC	67	0.2%	$667,143	$0	$0	$667,143
Private Insurance*	9,264	29.4%	$24,156,391	$71,879,536	$2,315,252	$98,351,180
Medicare*	6,962	22.1%	$22,515,893	$7,144,066	$470,891	$30,130,849
PrEP-AP	6,981	22.1%	$17,492,207	$0	$2,242,836	$19,735,043
SUBTOTAL	**31,548**	**100%**	**$283,344,319**	**$79,023,602**	**$5,028,979**	**$367,396,900**
Admin: ADAP	-	-	$5,267,523	$1,965,546	$993,698	$8,226,767
Admin: PrEP-AP	-	-	$0	$0	$5,556,172	$5,556,172
Admin: Enrollment	-	-	$0	$0	$0	$7,975,500
HMS	-	-	-$14,485,232	$0	$0	-$14,485,232
Early Action Package**	-	-	$0	$0	$0	$17,600,000
TOTAL	**31,548**	**100%**	**$274,126,610**	**$80,989,148**	**$11,578,849**	**$392,270,107**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
* Subgroup of 12,618 clients receiving assistance for premium payments and medical-out-of-pocket costs.
** Early Action Package expenditure accounts for Harm Reduction, SB-954, increasing the FPL to 600 percent, ADAP Open Formulary, and increasing the premium threshold.

TABLE 8: Difference Between November Estimate and 2024 Budget Act; Current Year 2024-25						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	1,595	19.3%	$9,500,620	$0	$0	$9,500,620
Medi-Cal SOC	12	18.3%	$132,452	$0	$0	$132,452
Private Insurance*	569	6.1%	$3,379,098	$5,692,513	$501,987	$9,573,598
Medicare*	193	2.8%	-$8,016,602	-$1,157,757	-$74,320	-$9,248,680
PrEP-AP	326	4.7%	$621,677	$0	$171,456	$793,134
SUBTOTAL	**2,695**	**8.5%**	**$5,617,245**	**$4,534,755**	**$599,123**	**$10,751,123**
Admin: ADAP	-	-	-$2,799,089	$71,134	$48,101	-$2,679,855
Admin: PrEP-AP	-	-	$0	$0	-$195,009	-$195,009
Admin: Enrollment	-	-	$0	$0	$0	-$150,000
HMS	-	-	-$1,888,308	$0	$0	-$1,888,308
Early Action Package**	-	-	$0	$0	$0	-$7,600,000
TOTAL	**2,695**	**8.5%**	**$929,848**	**$4,605,889**	**$452,215**	**-$1,762,048**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
* Subgroup decreased by 653 clients receiving assistance for premium payments and medical-out-of-pocket costs.
** The -$7.6 million difference between the November Estimate and the 2024 Budget Act for the Early Action Package is -$2.6 million in expenditures for increasing the FPL to 600 percent, ADAP Open Formulary, and increasing the premium threshold, which are enveloped in the respective client groups and service type expenditures as noted in Current Year 2024-25 expenditures (Table 6), and -$5 million for SB-954, which was vetoed by the Governor on September 25, 2024.

TABLE 9: November Estimate Caseload and Variable Expenditures; Budget Year 2025-26

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	9,396	25.1%	$249,523,961	$0	$0	$249,523,961
Medi-Cal SOC	88	0.2%	$908,835	$0	$0	$908,835
Private Insurance*	10,457	27.9%	$37,276,083	$90,112,051	$3,703,983	$131,092,117
Medicare*	7,197	19.2%	$13,072,953	$12,189,613	$1,248,367	$26,510,933
PrEP-AP	10,350	27.6%	$34,460,620	$0	$2,694,505	$37,155,125
SUBTOTAL	**37,488**	**100.0%**	**$335,242,453**	**$102,301,665**	**$7,646,855**	**$445,190,972**
Admin: ADAP	-	-	$2,715,277	$2,240,348	$1,145,979	$6,101,603
Admin: PrEP-AP	-	-	$0	$0	$5,384,963	$5,384,963
Admin: Enrollment	-	-	$0	$0	$0	$8,335,500
HMS	-	-	-$14,736,186	$0	$0	-$14,736,186
Early Action Package**	-	-	$0	$0	$0	$10,000,000
TOTAL	**37,488**	**100.0%**	**$323,221,543**	**$104,542,012**	**$14,177,797**	**$460,276,852**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
* Subgroup of 12,693 clients receiving assistance for premium payments and medical-out-of-pocket costs.
** Early Action Package expenditure accounts for Harm Reduction. Expenditures for increasing the FPL to 600 percent, ADAP Open Formulary, and increasing the premium threshold are accounted for in their respective client groups and service type expenditures.

TABLE 10: 2024 Budget Act Caseload and Variable Expenditures

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	8,275	26.2%	$218,512,685	$0	$0	$218,512,685
Medi-Cal SOC	67	0.2%	$667,143	$0	$0	$667,143
Private Insurance*	9,264	29.4%	$24,156,391	$71,879,536	$2,315,252	$98,351,180
Medicare*	6,962	22.1%	$22,515,893	$7,144,066	$470,891	$30,130,849
PrEP-AP	6,981	22.1%	$17,492,207	$0	$2,242,836	$19,735,043
SUBTOTAL	**31,548**	**100%**	**$283,344,319**	**$79,023,602**	**$5,028,979**	**$367,396,900**
Admin: ADAP	-	-	$5,267,523	$1,965,546	$993,698	$8,226,767
Admin: PrEP-AP	-	-	$0	$0	$5,556,172	$5,556,172
Admin: Enrollment	-	-	$0	$0	$0	$7,975,500
HMS	-	-	-$14,485,232	$0	$0	-$14,485,232
Early Action Package**	-	-	$0	$0	$0	$33,800,000
TOTAL	**31,548**	**100%**	**$274,126,610**	**$80,989,148**	**$11,578,849**	**$408,470,107**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
* Subgroup of 12,618 clients receiving assistance for premium payments and medical-out-of-pocket costs.
** Early Action Package expenditure accounts for Harm Reduction, increasing the FPL to 600 percent, ADAP Open Formulary, and increasing the premium threshold.

TABLE 11: Difference Between November Estimate 2024 Budget Act; Budget Year 2025-26

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	1,121	13.5%	$31,011,276	$0	$0	$31,011,276
Medi-Cal SOC	21	32.1%	$241,692	$0	$0	$241,692
Private Insurance*	1,194	12.9%	$13,119,692	$18,232,515	$1,388,731	$32,740,938
Medicare*	235	3.4%	-$9,442,940	$5,045,547	$777,476	-$3,619,916
PrEP-AP	3,369	48.3%	$16,968,413	$0	$451,669	$17,420,082
SUBTOTAL	**5,940**	**18.8%**	**$51,898,134**	**$23,278,062**	**$2,617,876**	**$77,794,072**
Admin: ADAP	-	-	-$2,552,246	$274,802	$152,281	-$2,125,164
Admin: PrEP-AP	-	-	$0	$0	-$171,209	-$171,209
Admin: Enrollment	-	-	$0	$0	$0	$360,000
HMS	-	-	-$250,954	$0	$0	-$250,954
Early Action Package**	-	-	$0	$0	$0	-$23,800,000
TOTAL	**5,940**	**18.8%**	**$49,094,934**	**$23,552,864**	**$2,598,948**	**$51,806,745**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
* Subgroup increased by 75 clients receiving assistance for premium payments and medical-out-of-pocket costs.
** The -$23.8 million difference between the November Estimate and the 2024 Budget Act for the Early Action Package is the expenditures for increasing the FPL to 600 percent, ADAP Open Formulary, and increasing the premium threshold, which are enveloped in the respective client groups and service type expenditures as noted in Budget Year 2025-26 expenditures (Table 9).

a) Medication-Only Clients

1. Medication:
   - 2024-25: Costs are projected to be $228 million (Table 6), $9.5 million higher than reported in the 2024-25 Budget Act (Table 8). The increase is driven primarily by lower monthly caseload offset with a higher cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $249.5 million (Table 9), $31 million higher than reported in the 2024-25 Budget Act (Table 11). The increase is driven primarily by the same factors above.
2. Health Insurance Premiums: There are no costs for medication-only clients.
3. Medical Out-Of-Pocket Costs: There are no costs for medication-only clients.

b) Medi-Cal SOC Clients

1. Medication:
   - 2024-25: Costs are projected to be $800,000 (Table 6), $132,000 higher than reported in the 2024-25 Budget Act (Table 8). The increase is driven primarily by higher monthly caseload and higher cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $909,000 (Table 9), $242,000 higher than reported in the 2024-25 Budget Act (Table 11). The increase is driven primarily by the same factors above.
2. Health Insurance Premiums: There are no costs for Medi-Cal SOC clients.
3. Medical Out-Of-Pocket Costs: There are no costs for Medi-Cal SOC clients.

c) Private Insurance Clients

1. Medication:
   - 2024-25: Costs are projected to be $27.5 million (Table 6), $3.4 million higher than reported in the 2024-25 Budget Act (Table 8). The increase is driven primarily by lower monthly caseload offset with a higher cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $37.3 million (Table 9), $13.1 million higher than reported in the 2024-25 Budget Act (Table 11). The increase is driven primarily by higher monthly caseload and higher cost per client per month.

2. Health Insurance Premiums:
   - 2024-25: Costs are projected to be $77.6 million (Table 6), $5.7 million higher than reported in the 2024-25 Budget Act (Table 8). The

increase is driven primarily by higher monthly caseload and higher cost per client per month than previously estimated.
- 2025-26: Costs are projected to be $90.1 million (Table 9), $18.2 million higher than reported in the 2024-25 Budget Act (Table 11). The increase is driven primarily by the same factors above.

3. Medical Out-Of-Pocket Costs:
   - 2024-25: Costs are projected to be $2.8 million (Table 6), $502,000 higher than reported in the 2024-25 Budget Act (Table 8). The increase is driven primarily by higher monthly caseload and higher cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $3.7 million (Table 9), $1.4 million higher than reported in the 2024-25 Budget Act (Table 11). The increase is driven primarily by the same factors above.

d) Medicare Clients

1. Medication:
   - 2024-25: Costs are projected to be $14.5 million (Table 6), $8 million lower than reported in the 2024-25 Budget Act (Table 8). The decrease is driven primarily by lower monthly caseload offset with a higher cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $13.1 million (Table 9), $9.4 million lower than reported in the 2024-25 Budget Act (Table 11). The decrease is driven primarily by the same factors above.
2. Health Insurance Premiums:
   - 2024-25: Costs are projected to be $6 million (Table 6), $1.2 million lower than reported in the 2024-25 Budget Act (Table 8). The decrease is driven primarily by higher monthly caseload offset with a lower cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $12.2 million (Table 9), $5 million higher than reported in the 2024-25 Budget Act (Table 11). The increase is driven primarily by higher monthly caseload offset with lower cost per client per month than previously estimated.
3. Medical Out-Of-Pocket Costs:
   - 2024-25: Costs are projected to be $397,000 (Table 6), $74,000 lower than reported in the 2024-25 Budget Act (Table 8). The decrease is driven primarily by higher monthly caseload offset with a lower cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $1.2 million (Table 9), $777,000 higher than reported in the 2024-25 Budget Act (Table 11). The increase is driven primarily by higher monthly caseload and higher cost per client per month than previously estimated.

e) PrEP-AP Clients

1. Medication:
   - 2024-25: Costs are projected to be $18.1 million (Table 6), $622,000 higher than reported in the 2024-25 Budget Act (Table 8). The increase is driven primarily by higher monthly caseload offset with a lower cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $34.5 million (Table 9), $17 million higher than reported in the 2024-25 Budget Act (Table 11). The increase is driven primarily by higher monthly caseload offset by lower cost per client per month.
2. Health Insurance Premiums: There are no costs for PrEP-AP clients.
3. Medical Out-Of-Pocket Costs:
   - 2024-25: Costs are projected to be $2.4 million (Table 6), $171,000 higher than reported in the 2024-25 Budget Act (Table 8). The increase is driven primarily by lower monthly caseload offset with a higher cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $2.7 million (Table 9), $452,000 higher than reported in the 2024-25 Budget Act (Table 11). The increase is driven primarily by higher monthly caseload and higher cost per client per month.

VII. Historical Program Data and Trends

Figures 1 – 3 describe clients served. Enrolled clients who do not incur program costs are excluded.

Figure 1 summarizes ADAP clients served by fiscal year and those also receiving insurance assistance.

In FY 2023-24, a total of 27,442 individuals received ADAP services (with 9,919 of those being insurance assistance clients). For FY 2024-25, OA projects the total ADAP caseload to decrease to 26,936 individuals (with insurance assistance clients increasing to 11,965). For FY 2025-26, OA projects the total ADAP caseload to increase to 27,138 individuals (with insurance assistance clients increasing to 12,693).

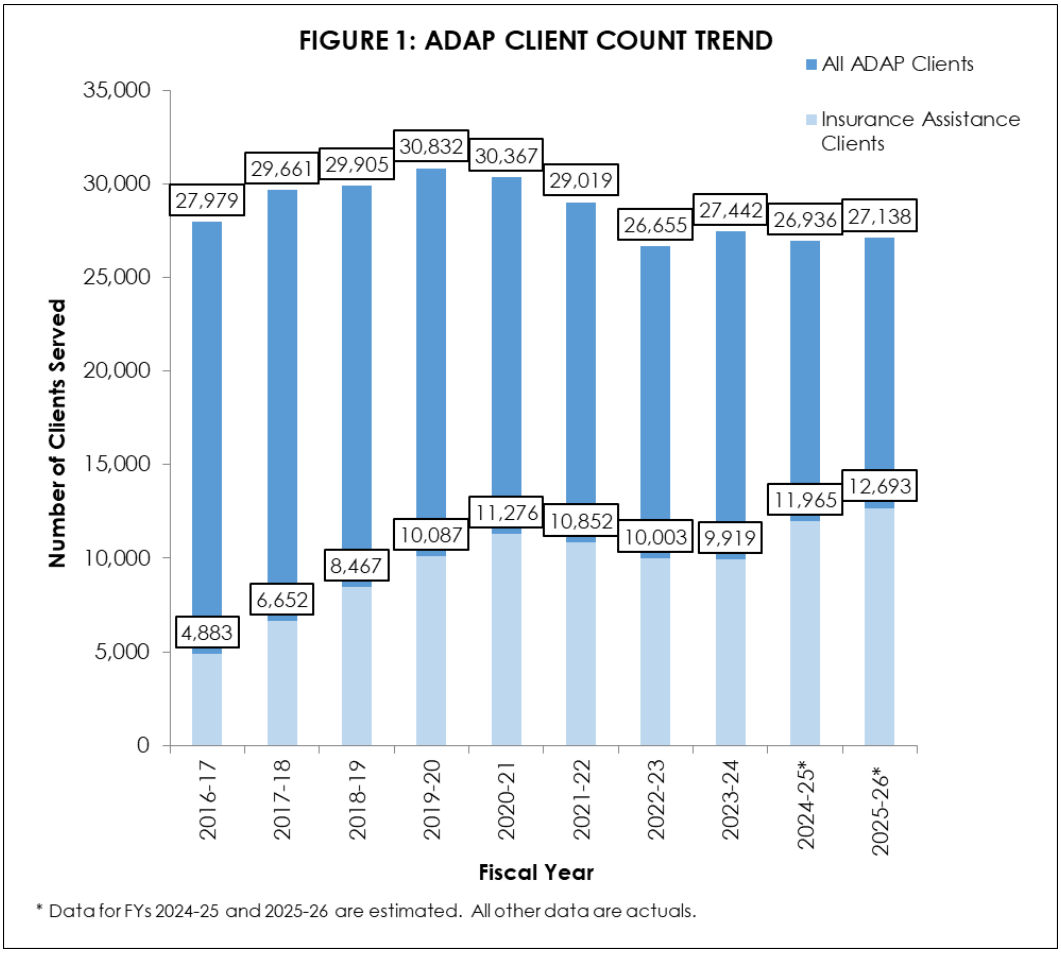
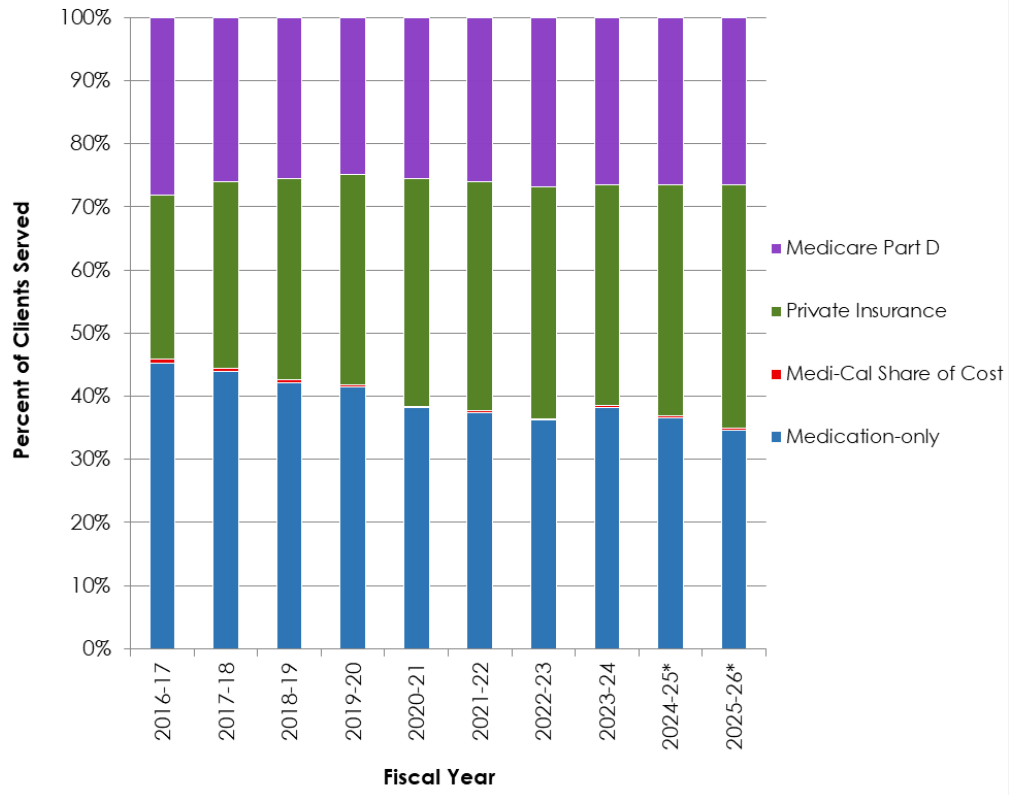


Figure 2 summarizes the proportion of ADAP medication program clients enrolled in the various payer groups by fiscal year.

For FY 2024-25, of the projected 26,936 ADAP medication program clients, the payer source percentages are estimated to be 36.6 percent Medication-only, 36.5 percent Private Insurance, 26.6 percent Medicare Part D, and 0.3 percent Medi-Cal SOC. For FY 2025-26, of the projected 27,138 ADAP medication program clients, the payer source percentages are estimated to be 34.6 percent Medication-only, 38.6 percent Private Insurance, 26.5 percent Medicare Part D, and 0.3 percent Medi-Cal SOC.

FIGURE 2: PERCENT OF ADAP MEDICATION PROGRAM CLIENTS BY PAYER SOURCE



* Data for FYs 2024-25 and 2025-26 are estimated. All other data are actuals.

Figure 3 summarizes PrEP-AP clients served by fiscal year.

In FY 2023-24, a total of 5,324 individuals received PrEP-AP services. For FY 2024-25, OA projects the total PrEP-AP caseload to increase to 7,307. For FY 2025-26, OA projects the total PrEP-AP caseload to increase to 10,350.

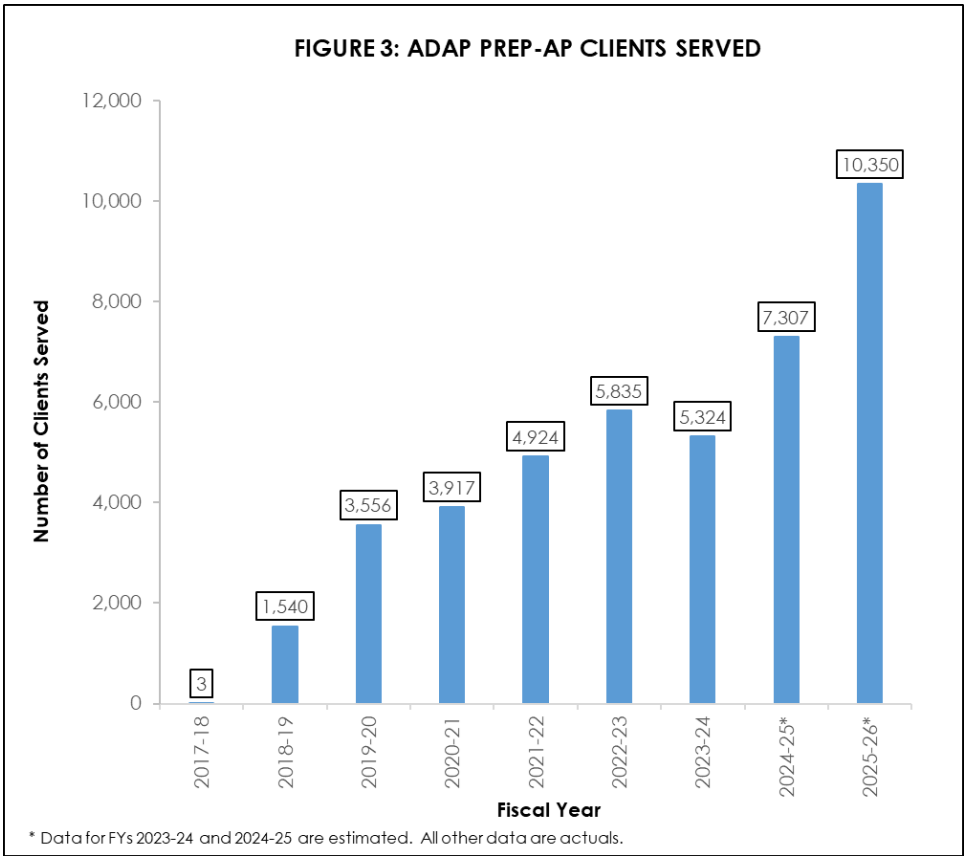
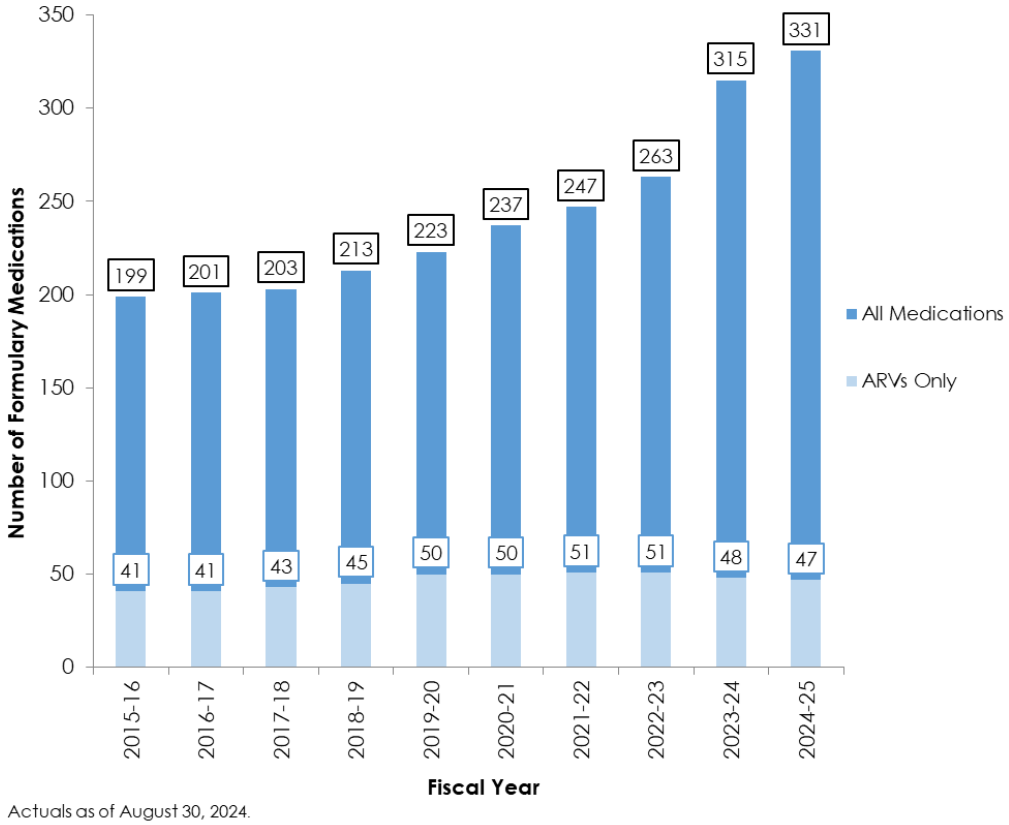


Figure 4 summarizes the number of medications on the ADAP formulary by fiscal year; the number of ARV medications is also shown.

In FY 2023-24, a total of 315 medications were on the ADAP formulary (with 48 of those being ARVs). As of August 30, 2024, there are 331 medications on the ADAP formulary (with 47 of those being ARVs).

FIGURE 4: NUMBER OF MEDICATIONS ON ADAP FORMULARY



Actuals as of August 30, 2024.

Additions to the ADAP Formulary

The following medications were added to the ADAP formulary on:

March 15, 2024:

- benzathine benzylpenicillin (Extencilline®), non-ARV, antibiotic

March 29, 2024:

- warfarin (Coumadin®), non-ARV, anticoagulant
- dabigatran (Pradaxa®), non-ARV, anticoagulant
- apixaban (Eliquis®), non-ARV, anticoagulant
- rivaroxaban (Xarelto®), non-ARV, anticoagulant

July 1, 2024:

- JYNNEOS®, non-ARV, vaccine

July 3, 2024:

- raloxifene (Evista®), non-ARV, selective estrogen receptor modulator
- bazedoxifene/conjugated estrogens (Duavee®), non-ARV, estrogen agonist/antagonist

July 9, 2024:

- digoxin (Lanoxin™), non-ARV, digitalis glycosides
- eplerenone (Inspra®), non-ARV, mineralocorticoid receptor antagonists
- isosorbide dinitrate and hydralazine hydrochloride (Bidil®), non-ARV, nitrates
- sacubitril/valsartan (Entresto®), non-ARV, angiotensin receptor neprilysin inhibitor
- valsartan (Diovan®), non-ARV, angiotensin receptor blockers
- cariprazine (Vraylar®), non-ARV, atypical antipsychotics
- lithium carbonate (Eskalith®), lithium carbonate controlled-release (CR)(Eskalith CR®), lithium carbonate extended-release (Lithobid®), non-ARV, antimanic agent
- lurasidone hydrochloride (Latuda®), non-ARV, atypical antipsychotics
- insulin degludec (Tresiba®), non-ARV, long-acting basal human insulin analog

Deletions from the ADAP Formulary

There are currently no deletions to the ADAP formulary.

VIII. Current HIV Epidemiology in California

Approximately 143,000 people in California living at the end of 2022 had been diagnosed with HIV and reported to OA. Since the epidemic began in 1981, approximately 110,000 Californians diagnosed with HIV have died, with over 2,100 dying in 2022 alone.

Of the approximately 143,000 people living with diagnosed HIV (PLWDH) in California, approximately 40.7 percent are Latinx; 34.1 percent are White; 16.4 percent are Black/African American; 4.4 percent are Asian; 4.0 percent are multi-racial; 0.2 percent are American Indian/Alaskan Native; and 0.2 percent are Native Hawaiian/Pacific Islander. While Latinx and Whites make up the largest percentage of PLWDH in California, the rate of HIV among Blacks/African Americans is substantially higher (1,012.3 per 100,000 population, versus 319.5 per 100,000 among Whites and 364.8 per 100,000 among Latinx).

Most of California's living HIV cases are attributed to male-to-male sexual transmission (66.3 percent); 8.2 percent of living cases are attributable to high-risk heterosexual contact (defined as contact with a sex partner or partners of the opposite gender who are either known to be HIV infected or known to be someone who injects drugs, has hemophilia, or is a man who has sex with other men); 6.0 percent to men who have sex with men who also inject drugs; 5.3 percent to injection drug use; 1.9 percent to transgender sexual contact; 0.5 percent to perinatal exposure; and 11.9 percent to other or unknown sources including other heterosexual contact.

From 2018 to 2022, there was an average of approximately 4,600 new HIV cases reported in California each year. Please note COVID-19 may have impacted rates of testing as well as reporting completeness in 2020. The number of PWH in the state is expected to grow by two to three percent each year for the foreseeable future until more progress is made in preventing new HIV infections. This increase is attributed to stable incidence rates and longer survival of those infected primarily due to the effectiveness and availability of treatment.

IX. Plan for Modernization and Expansion

Per SB 159 SEC, 83 (b), CDPH shall submit to the Legislature, as part of the 2025–26 Governor's Budget, a plan for modernization and expansion of ADAP and related programs with a focus on addressing the epidemic of HIV/AIDS in California, including, but not limited to assumptions included in the 2025-26 November Estimate: Increasing ADAP and PrEP-AP Income Limits from 500 Percent to 600 Percent FPL, an ADAP Open Formulary, and Increasing Premium Threshold for Insurance Assistance Programs.

The plan shall be developed in consultation with stakeholders and the Legislature and should consider whether the proposed activity is an eligible use of the ADAP Rebate Fund, availability of funding, and whether it advances access to services.

The Modernization and Expansion Plan is inclusive of, but not limited to, the following assumptions (in conjunction with the three aforementioned assumptions): EB-HIPP Program Expansion to ADAP Clients who are not the Primary Insured, Payments for Medicare Part B Premiums, Payment of Medicare Part B Medical Out-of-Pocket Costs, PrEP Medication: Lenacapavir, and Gilead's Plans to Discontinue Patient Assistance Program for Truvada.

Through ongoing stakeholder engagement outlined below, CDPH will continue to develop enhancements to ADAP and related programs in consultation with stakeholders and the Legislature, while ensuring that proposed activities are an eligible use of the ADAP Rebate Fund. Program enhancements will be proposed on an ongoing basis through the annual November Estimate process.

Stakeholder Engagement:
OA conducts effective strategic stakeholder engagement across multiple efforts and programs:

ADAP/PrEP-AP Stakeholder Engagement
The ADAP Branch Monthly Enrollment Worker Calls are conference calls designed to engage ADAP and PrEP-AP stakeholders in providing program updates, share best practices among attendees, and provide specific presentation topics relevant to ADAP and PrEP-AP programs. Required attendees include all ADAP and PrEP-AP Enrollment Workers. Enrollment Workers conduct enrollment services for ADAP and/or PrEP-AP at contracted enrollment sites, which include community-based non-profit organizations, clinics, medical providers, and case management service providers. The Monthly Enrollment Worker Calls include an open forum for Enrollment Workers to ask questions, voice concerns, and provide programmatic feedback, and suggestions.

ADAP facilitates two additional stakeholder bodies that inform ADAP and PrEP-AP programs and initiatives. The ADAP/PrEP-AP Enrollment Worker Advisory Committee (AEWAC) is comprised of ADAP and PrEP-AP Enrollment Workers from high volume enrollment sites who consult on matters of ADAP and PrEP-AP policy and accessibility of the programs for clients. The Medical Advisory Committee (MAC) advises on medications added to the ADAP Formulary and consists of health care professionals, and individuals with expertise and/or experience, that benefit the program and the population ADAP serves, including HIV-specialized physicians, pharmacists, psychiatrists, treatment advocacy representatives, and community representatives.

California Planning Group (CPG): HIV, STD, Hepatitis C and Harm Reduction
OA's HIV Care Branch, HIV Prevention Branch, and the Sexually Transmitted Diseases (STD) Control Branch (STDCB) collaborate in conducting all strategic community engagement activities of the statewide planning body, California Planning Group: HIV, STD, Hepatitis C and Harm Reduction (CPG). CPG, OA, and STDCB meet publicly in-person or virtually twice a year to conduct CPG business, discuss prevailing issues in the community, and to build capacity amongst the community members. Select ADAP staff serve as staff liaisons to the CPG and CPG feedback is solicited to inform ADAP policy and initiatives.

Monthly Office of AIDS & Sexually Transmitted Diseases/Hepatitis Stakeholder Engagement Calls
Monthly stakeholder webinars are designed to engage OA stakeholders in providing program updates, share best practices among attendees, and provide specific presentation topics addressing HIV-related emerging issues. Required attendees include all funded Local Health Jurisdictions (LHJs), Community Based Organizations (CBOs), and CPG members. Many CBOs are contracted as ADAP and/or PrEP-AP Enrollment Sites and provide enrollment services directly to clients. Stakeholders are invited to contribute agenda items and to discuss issues.

Following strategic stakeholder engagement across multiple efforts and programs, OA proposed expansions to ADAP and PrEP-AP through the 2025-26 November Estimate that advance access to services. The assumptions are eligible uses of the ADAP Rebate Fund and there is funding available for these activities.